ORTHODONTIA PROVIDER CERTIFICATION

Name: _____

Provider Number: _____

By initialing the applicable items listed below and signing this form, I certify that I meet the (Section 51223) Title 22 requirements for a 'qualified orthodontist'. I understand that I am required to complete and submit this certification as a prerequisite for providing orthodontic services for handicapping malocclusion to eligible Medi-Cal beneficiaries.

1. ☐ I confine my practice to the specialty of orthodontics.

and (at least one of the following)

2. ☐ I have successfully completed a course of advanced study in orthodontics of two years or more in programs recognized by the Council on Dental Education of the American Dental Association.

or

3. ☐ I have completed advanced training in orthodontics prior to July 1, 1969 and am a member of or eligible for membership in the American Association of Orthodontists.

_____

Signature Date

PROOF OF COURSE COMPLETION
(As defined in #2 and #3)
MUST BE ATTACHED